NEWS

Cholera epidemic threatens Sierra Leone

Sierra Leone faces the threat of a major epidemic of cholera with the onset of the rainy season, according to the World Health Organisation. The situation is particularly grave for the two million people displaced by the country's civil war. Already 1709 cases of cholera have been registered in the capital, Freetown, with 57 deaths.

Freetown's population has doubled since the start of the war in 1991, with 750 000 refugees camping out in the town. The insurgent Revolutionary United Front is now within 32 km of the capital, and large tracts of the country are inaccessible to the various agencies and charities working there.

The military government is unable to guarantee safe conduct for aid by road even to sizeable provincial towns. Doctors and aid workers are forced to rely on a private helicopter service for personal transport.

"As many as 10 000 people were affected by the disease last year," said Dr Everest Njelesani, the WHO's representative in Sierra Leone. "We fear that this time, unless urgent measures are taken, it could be even worse. The rainy season has just started, provinces are cut off from the capital, medical supplies are scarce, and, on top of that, there are two million displaced persons who should be sheltered and fed."

Little provision has thus far been made for the refugees, and many will face the rains without so much as canvas over their heads. Experts from the WHO who recently toured the country predict that pneumonia is likely to claim the lives of many children, and the standing water will also bring out the anopheles mosquito, which in this area carries a highly drug resistant strain of *Plasmodium falciparum*. But the greatest problems are the lack of safe drinking water and the attendant risks of cholera and dysentery.

At one site in Freetown the 6000 refugees have to fetch water from a source 20 minutes' walk away and have no latrines. As a result there have been 277 cases of cholera and two deaths already among that group. The health department has set up five centres to treat cholera in Freetown and is organising mobile clinics. The WHO's Sierra Leone office is assisting the government mobile health teams, which provide free primary care to displaced people. Medicines and vaccines, however, are lacking.

Many of the staff of the 13 district health authorities have been displaced to Freetown, and war and poverty have led to a brain drain of the country's doctors. Aid agencies such as Médecins Sans Frontières and Oxfam have stepped into the role in many districts.

Dr Fabrizio Bassani, director of the WHO's emergency and humanitarian aid division, feared that logistic problems may scupper the best efforts of international agencies.

"None of the major roads are safe. Only a small proportion of the displaced population lives in camps. Some are absorbed into families in large towns, while others are hiding in makeshift camps. WHO urgently needs funds to continue and extend its work." he said. The war has been a particularly brutal affair, with the Revolutionary United Front kidnapping teenagers and allegedly indoctrinating them with a combination of crack cocaine and Rambo videos. Last month a Revolutionary United Front unit went on a killing spree in the mining town of Koine, leaving up to 200 people dead.

Ironically, one of the Revolutionary United Front's main demands is for a free national health service.—OWEN DYER, freelance journalist, London

DAVID BROWNE

Catching cholera?

NHS staff should work in developing world, says princess

Senior managers in the British health service are being encouraged to release staff who want to work on projects in developing countries. A letter has been issued from the NHS Executive asking employers to look favourably on such requests. The move has been welcomed by the Princess Royal, who, in her role as patron of the International Health Exchange, has been critical of negative attitudes in the NHS towards people who want to volunteer for work overseas.

Speaking to health managers last week at the conference of the National Association of Health Authorities and Trusts in Glasgow, she said that development agencies had difficulty in recruiting experienced health professionals. People interested in volunteering feared that their career prospects would be affected adversely if they left for a post

Headlines

Nurses vote to end no strike rule: The Royal College of Nursing has voted to end its no strike rule. In a 39% turn out of the union's 300 000 members 99 760 voted for and 5529 voted against a change in the rules.

CMO launches primary care initiative: The government's chief medical officer, Dr Kenneth Calman, has set up a working group for one year to advise the NHS Executive on how public health can support primary care. The initiative is supported by the Royal College of General Practitioners, the Faculty of Public Health Medicine, and the National Association of Fundholding Practices.

Consultants endorse new merit award scheme: The BMA's Central Consultants and Specialists Committee has endorsed the new proposals for restructuring C merit awards and replacing them with five discretionary points above the top of the consultant scale.

Michigan closes Dr Kevorkian's suicide clinic: Officials closed down the clinic in which Dr Jack Kevorkian, a retired pathologist, presided over the assisted suicide of Erika Garcellano, last week. Garcellano had Lou Gehrig's disease. Kevorkian has already been involved in over 24 deaths over the past five years.The state of Michigan does not recognise the right to die.

Charter proposed for care of ethnic minorities: A report by John Mayberry and Pamela de Chazal on doctors' communication with patients from ethnic minorities, *The Sambhro Report*, calls for a commitment to formal and practical education in medical schools and nursing colleges on all aspects of the life of people in minority communities in Britain and for trusts and authorities to ensure continuing cultural training and awareness.

Japan promises new aid to people with Minamata disease: The Japanese government has proposed a new compensation scheme for the people who were poisoned with seafood containing mercury in the 1950s and 1960s and now have Minamata disease. The government and the firm responsible, Chisso Corporation, have compensated 3000 severely affected victims, but until now the 10000 people with milder symptoms have not been recognised.

overseas. The Princess Royal said, "People returning report negative attitudes and a lack of interest. Working in other countries appears to give a negative signal to employers. Looking beyond your own borders is taken as a sign of being too independent, of a lack of commitment to the NHS."

The princess contrasted the position in Britain with that in other countries, notably France and the Netherlands, where experience of working overseas is judged to be an advantage. She said that the NHS could benefit greatly by encouraging the release of staff to help in countries with only a fraction of the resources available in the developed world. "Volunteers learn very fast about the most effective forms of health care. Staff who have worked in this kind of environment are likely to have developed greater all round competence than if they spent the equivalent time in the NHS." She told managers that she was fully aware of the challenges they faced in running their own services but said that a longer term vision was needed to create a climate in the NHS that "positively welcomes involvement with developing countries and enables experience to be kept alive in the search for new solutions in today's service."

The government has given its backing to a report from the International Health Exchange that calls for changes in attitudes in the NHS, and the letter from the NHS Executive asks managers to encourage both the release and the re-entry of staff intending to work overseas.

During an earlier session of the conference that looked at the issue of outcomes of treatment it was suggested that hospitals should face financial penalties if they provided poor standards of treatment. Dr Harry Burns, director of public health for Greater Glasgow Health Board, said that the constant flow of media stories about missed fractures, inappropriately discharged patients, and accidental overdoses left the public convinced that there was no culture of quality in the NHS.

UPPA

The Princess Royal

Research from Glasgow has shown substantial variations in survival rates associated with certain treatments between different hospitals and different doctors. The health board has used this information to concentrate some forms of cancer treatment at the centres producing the best results. Dr Burns suggested going further by paying hospital trusts on the basis of clinical results as well as clinical episodes. If a 95% survival rate was expected from a particular treatment and only 85% was achieved, penalties should follow.

"Poor outcomes should lead to poor income for a trust," he said. "We might then see more chief executives taking a close interest in clinical audit and managing clinical care delivery more intensively rather than adopting a relatively hands off approach as is common at the moment."—BRYAN CHRISTIE, health correspondent, the *Scotsman*

Syphilis soars in Russia

The number of adults with syphilis in Russia has increased 15-fold since the collapse of the Soviet Union. In children the rate is now 20 times higher than it was four years ago. The health ministry this week said that 126500 cases of the disease had been registered over the past year compared with 7900 in 1990. "The growing rate of venereal disease in Russia over the past few years worries us immensely," said Lilia Tikhonova, the ministry's chief specialist on sexually transmitted diseases.

In children the increase has been from 38 cases in 1990 to 761 this year; most of these cases are a result of sexual transmission. "The complete perversion of our society's morals is one of the reasons for such a sad situation," said Tikhonova. She blamed the rise on the rapid growth of child prostitution and the influx of homeless people and refugees into Russia's cities. Russia's homeless people are often blamed for epidemics, including the recent rises in cholera and diphtheria.

Tikhonova also blamed irresponsible "miracle cures" for the rise in syphilis. These are advertised as curing the disease in a couple of days, and most people use them rather than face the embarrassment of seeing a specialist.

In communist Russia patients were forced to register passport details and previous sexual contacts. Future sexual contact was forbidden for a period, and anyone breaking these rules faced up to five years in jail. Current criminal law punishes only people who knowingly infect their sexual partners.

In Ukraine, which has seen a similar increase in sexually transmitted diseases, health officials are blaming condoms that are being sold on the black market. Over the past five years cheap foreign condoms have flooded the market.—MIRANDA INGRAM, Moscow bureau chief, the *European*

Labour unveils its health reforms

A Labour government would end general practice fundholding in England and replace it with a system of commissioning, according to the party's leader, Mr Tony Blair. This is just one of the changes proposed by Labour in its policy document on health launched last week.

Mr Blair spoke of "ambitious new standards for achieving better quality" and said: "We are not reversing all the Conservative reforms. We keep what is good. We remove what is bad. We extend greater power for hospitals and doctors. We remove the wasteful Tory internal market, which is costing billions of pounds."

Labour wants more power for family doctors to refer patients to the specialist or hospital that best suits their needs and more scope for hospitals to be managed locally and to run their own affairs. Labour would extend the system of commissioning for general practitioners which is already operating in some areas and involves family doctors forming informal partnerships with health authorities.

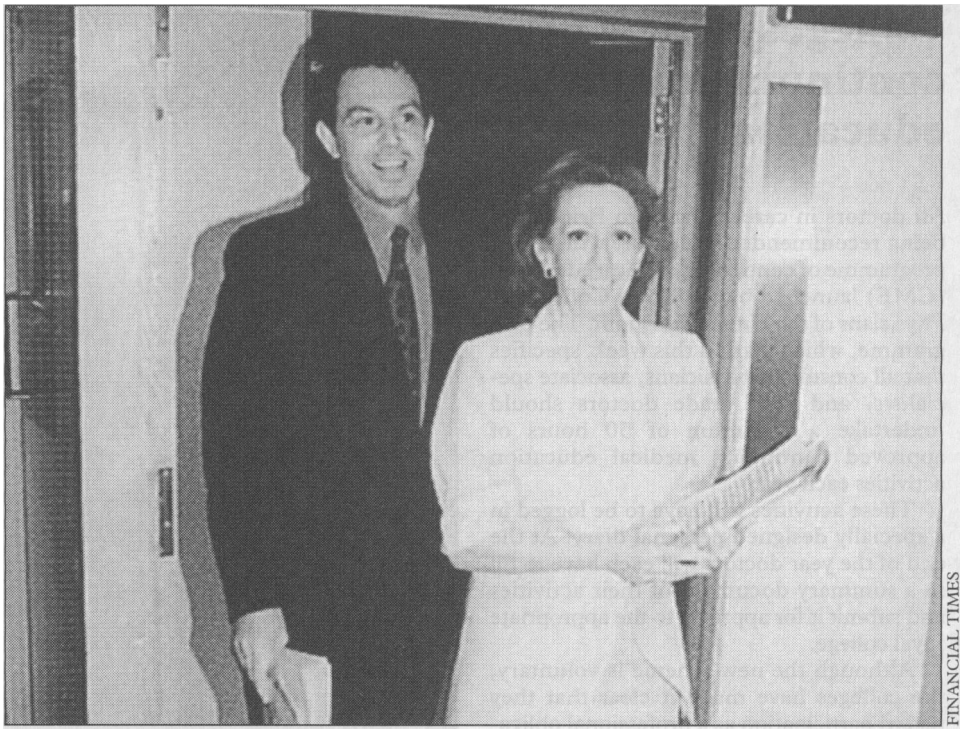
The document talks of introducing targets based on evidence of benefit to health. Targets associated with inequality—for instance low birth weight—would be a first step. Asthma would be another target: "Inclusion of asthma in the Health of the Nation would influence our transport and environment policy; promote local awareness campaigns; encourage cooperation between health and local authorities; and generate a shift of attention to primary care."

Labour also has strong views on health promotion, believing that the existing Health Education Authority has too narrow a focus. The document cites accidents at work, tooth decay, smoking, and HIV and AIDS as areas for improved health promotion.

Overall, Labour has five key aims: to attack inequalities in health; to improve general practitioner services; to extend patients' choice with more information; to develop evidence based medicine; and to provide better services for elderly people.

The document makes several suggestions involving more weekend working for NHS staff—for instance, the opening of day centres at weekends to boost care in the community. Mr Blair said that many of Labour's proposals would not require new money: "It is not merely a question of extra resources for the NHS. It is also a question of money that has been wasted in the health service—hundreds of millions of pounds. It is also demoralisation of people within the NHS ....Everywhere I go there is a great degree of anger at the way the NHS is being disrupted and reformed with little or no consultation."

Health trusts would be replaced by local health services. The shadow health secretary, Margaret Beckett, said: "There is no other reason for trusts owning their own assets than as a staging post to privatisation. Our NHS will be a single organisation working locally and nationally with shared objectives."—CLAUDIA COURT, *BMJ*



FINANCIAL TIMES

Tony Blair and Margaret Beckett announce Labour's health policy

Court rules against suing in child abuse cases

Local authorities in Britain cannot be sued if they wrongly take children into care or leave them unprotected when they should have acted, five law lords ruled last week. The judgment by the House of Lords in two test cases, which had been anxiously awaited for eight months, will halt dozens of cases pending against local councils over the exercise of their child protection functions.

The judgment also protects paediatricians and child psychiatrists from actions for negligence over their investigation and advice in cases of suspected child abuse. Had the point been taken after the child abuse crisis in Cleveland, the £1m settlement for the families that were involved could probably have been avoided.

M, now aged 12, and her mother, 29, had sued the London Borough of Newham, Newham Health Authority, and a child psychiatrist, Dr Eileen Vizard, after the girl was taken into care at the age of 4 and separated from her mother for nearly a year. The decision was taken after Dr Vizard wrongly concluded that the girl had been sexually abused by her mother's boyfriend. In fact the abuser was a cousin with the same first name.

In the second case the Ps, a family of five children aged between 5 and 12, sued Bedfordshire County Council for knowingly leaving them to suffer at least five years of emotional abuse and neglect from their parents before taking them into care. Reports about their plight from relatives, police, their general practitioner, the head teacher of their school, and the National Society for the Prevention of Cruelty to Children dated back to 1987, but the council delayed seeking care orders until October 1992.

In both cases lawyers for the councils asked the High Court to strike out the claims, arguing that individuals harmed by any failure to carry out their duties properly had no right to sue for damages. All the defendants deny that they were negligent or in breach of their statutory duty, and the court will not now be called on to decide the issue.

The High Court struck out the claims, and the Appeal Court confirmed the decision by a 2 to1 majority. The master of the rolls, Sir Thomas Bingham, would have allowed the children in both cases, though not the mother in the case of M, to sue for negligence. Delivering the leading judgment in the House of Lords, Lord Browne-Wilkinson said that to allow councils to be sued for negligence over their child protection duties would "cut across the whole statutory system set up for the protection of children at risk." The system was interdisciplinary, with the police, educational bodies, doctors, and others having a role, and involved joint recommendations, discussions, and decisions. To introduce into the system a duty of care enforceable against only one of these bodies would be "manifestly unfair." To impose it on all would lead to "almost impossible problems of disentangling."

If they were to be liable for damages local authorities might adopt a more cautious and defensive approach, leading to delays, which would prejudice those who had suffered child abuse, and a heavier workload, which would reduce the time available for other children to be dealt with. "In my judgment the courts should proceed with great care before holding liable in negligence those who have been charged by parliament with the task of protecting society from the wrongdoings of others," said Lord Browne-Wilkinson.—CLARE DYER, legal correspondent, *BMJ*

Colleges review continuing medical education

All doctors in career grades in Britain are being recommended to comply with a new programme of continuing medical education (CME) launched by the Royal Colleges of Physicians of the United Kingdom. The programme, which started this week, specifies that all consultant physicians, associate specialists, and staff grade doctors should undertake a minimum of 50 hours of approved continuing medical education activities each year.

These activities will have to be logged in a specially designed personal diary. At the end of the year doctors will each have to fill in a summary document of their activities and submit it for approval to the appropriate royal college.

Although the new scheme is voluntary, the colleges have made it clear that they regard participation as a professional obligation. "We will do random spot checks on the diaries and keep a whitelist of doctors who comply with the requirements," said Professor Sir Lesley Turnberg, president of the Royal College of Physicians of London. "There will be consequences for those who fail to get on it without good reason. In our view, consultants who do not participate in the wide range of opportunities that there are for CME are not likely to be suitable to train junior doctors. If we have clear evidence that they are not following our recommendations on CME they will have their facilities to train juniors removed."

The colleges' scheme, which is in line with similar schemes that have been set up or are in the process of being developed by the other royal colleges, acknowledges that continuing medical education comes in many shapes and forms. Thus the requirements stipulate that the 50 hours should include a mixture of "internal" and "external" activities. Internal activities are primarily local activities such as attendance at hospital grand rounds and audit meetings. Examples of external activities include college or society based clinical meetings, workshops, and symposiums specifically held for continuing medical education.

Self directed learning activities, such as exchange visits between peers, research, independent study, and small study group work, are increasingly seen as effective ways to learn. Such activities can be approved for credits for continuing medical education under the new scheme, provided that they are agreed beforehand with the regional royal college adviser.

Sir Lesley Turnberg said: "The advantage of putting CME on this formal basis is that it sends a clear signal both to doctors and to hospital managers that this is a necessary activity. I think most managers are supportive of CME in principle but they are very concerned about the cost. It's not so much the cost of going to meetings but of providing continuous cover for patients' care. —TESSA RICHARDS, *BMJ*

ASSOCIATED PRESS

Living in a time warp; a leper colony in Japan

Japan could unlock its people with leprosy

Tokyo's Ministry of Health and Welfare has decided to push for the abolition of a law that means that Japan still isolates many people with leprosy. Almost half a century after effective treatment for leprosy was first developed, about 5800 people with the disease live locked up in 15 sanatoriums funded by the state, cut off from the outside world and conveniently forgotten.

But this primitive state of affairs is about to change. Ministers are to push for abolition of the 1907 Leprosy Prevention Law, under which people with leprosy are quarantined for life. If all goes according to plan the law will be scrapped by the Diet (parliament) next year.

"After a great deal of thought we have decided that the law as it stands is out of date and absurd. In 1907 we classified leprosy as incurable and contagious. But it is extremely difficult to catch, and for 40 years or more it has been easy to cure with modern drugs," said Hiroshi Choda, a spokesman for the health ministry.

The leprosy law was revised in 1953, from which time any people newly diagnosed as having the disease were free to live wherever they liked. But those who had been diagnosed before the reform were not released. Most residents of Japanese leprosy homes have been there for over four decades. Their average age is over 70.

The change in the law was recommended by the Japan Leprosy Association, a group of doctors involved in treating the disease, who studied the issue for a year before offering a report to the health ministry. The advice came as a surprise to many, since it was the association that was chiefly responsible for keeping the law on the books for so long. Members of the association, most of whom earn their living at the government funded leprosy sanatoriums, continued to argue that freely socialising people with leprosy were a public health risk long after other industrialised countries decided that they were not.

Now they are extremely embarrassed at these past pronouncements. "Leprosy victims have lived absolutely miserable lives in quarantine," admitted the association's researcher Fumishige Minagawa. "We should have set them free long ago. Isolating them serves no useful purpose and probably contributes to the social stigma attached to the disease."

This last point is important. Very ill people are taboo in Japan, and perhaps only patients with AIDS endure more prejudice than those with leprosy. "Maybe one reason for the lepers' long isolation was the prejudice that most Japanese people feel towards them," said Choda. "Some officials felt that if they were quarantined they would be protected from this."

In fact, the opposite happened. Residents of sanatoriums grew lonely in enforced exile, and the fact that they were in quarantine made friends fearful of visiting them. Some received no visitors at all.

On their release, former inmates will probably be provided, at government expense, with enough money to rent a small apartment and to buy food and daily necessities. But some may be too used to captivity and unwilling to enter the outside world, according to Choda.

"The oldest sufferers will probably not want to move," he said. "They just wouldn't be able to cope with the upheaval."—ROBERT GUEST, Tokyo correspondent, *Daily Telegraph*

Juveniles still sent to British prisons

The number of 15 and 16 year old boys held in British prisons while awaiting trials has risen by 86% in just over a year, says a report from the National Association for the Care and Resettlement of Offenders (NACRO). The increase goes against the advice of the chief inspector of prisons, Judge Stephen Tumim, who has repeatedly warned that adult prisons put juveniles at risk of self harm and suicide. In a Home Office report in 1991 he said that in prison "the young are particularly vulnerable. They are more likely than adults to lack the inner resources to deal with being held in a local prison....Self-mutilation and suicide can also become a fixed part of a sub-culture."

Nearly 1500 juveniles were sent to prison while awaiting trial between October 1993 and September 1994. Two thirds were accused of non-violent offences, mostly burglary, and the average time spent in prison was one and a half months. NACRO believes that in many cases social workers are not in court and that juveniles could end up in prison without their family knowing.

Imprisonment is unevenly distributed in terms of both ethnic group and geography. In Birmingham over half the juveniles sent to prison were recorded as "black" or "other," as were over 40% of juveniles in Manchester. Devon and certain areas in London, such as Hammersmith and Fulham, only rarely put juveniles in custody.

When juveniles turn up at prison there is often little information available about them. "One senior probation officer told us that if you handed in a stray dog at a police compound you would have to have more paperwork," said Declan Kerr, policy development officer for NACRO. "We seem to be able to imprison children with impunity.

"There is no continuity between their lives outside and inside prison. They may have been in prison before and tried to take their own lives or have medical problems, but that information isn't available. They are then locked up for 23 hours a day and have to toughen up or come to serious grief."

The Criminal Justice Act 1991 was meant to stop juveniles being remanded in prisons. NACRO recommends that government departments should produce a code of practice for pretrial proceedings and fund alternative options to prison for juveniles awaiting trial.—LUISA DILLNER, *BMJ*

A Crisis in Custody is available from NACRO, 169 Clapham Road, London SW9 OPU, price £5.

French government cracks down on abortion protests

Four members of an antiabortion group were sentenced to 18 months' imprisonment and fines of £15 000 last week by a court in Roanne, near Lyons in France. This is the first time that a French court has jailed antiabortion protestors. During the same week the National Assembly said that antiabortion protesters were not eligible for the traditional amnesty granted to minor offenders that marks presidential elections.

The two events suggest that the government and courts are taking a tougher stance on challenges to abortion laws. Abortion has been legal since 1975, and an act passed in 1993 made it a criminal offence to obstruct a legal abortion.

More than 100 antiabortion protests have been held in France in the past five years, and the pace has increased in recent months. The protestors at Roanne rushed into the local hospital's operating room, where abortions are performed, and chained themselves in the fetal position. In the same week eight protesters rushed into the obstetrics department of the hospital at Annecy, near the Swiss border, and padlocked themselves to furniture and equipment.

Despite of the decision of the Roanne court and parliament's exclusion of antiabortionists from the amnesty list, feminist groups are deeply concerned at the attacks on women's rights. Socialist deputy Veronique Neiertz, who proposed the amendment excluding antiabortion activists from the amnesty, said that antiabortion raids "constitute terrorism against women and the medical community."

American antiabortion groups such as Human Life International and Operation Rescue are trying to attract European support. Last week Vernon Kirby of Human Life International told the *International Herald Tribune* that his group provides European organisations with publicity material, advice, and speakers but that it does not advocate violence. He said, however, that Pope John Paul II's recent encyclical on human life had endorsed civil disobedience against unjust laws.

Groups that support abortion occasionally retaliate by using the same tactics. Recently a proabortion group threw paint and tear gas into a church in Lyons during mass.—ALEXANDER DOROZYNSKI, medical journalist, Paris

CROWN COPYRIGHT

Unsuitable for children

French prosthesis company accused of fraud

A two year investigation into an alleged racket in hip prostheses has shown that the French social security's health insurance branch was defrauded of Fr 50m (£6.5m) by a company that sold unauthorised and overpriced hip prostheses. The company is also said to have paid doctors "royalties" to list the devices as having government. approval.

The investigation covered 120 local health insurance branches of the social security system and has led to one man—Jean-Claude Bouvet—being placed under judicial examination on charges of forgery. He is also charged with fraud regarding the quality of merchandise to the extent that it endangers the health of treated patients. Bouvet is chief executive of the Société Biomécanique Intégrée in Brétigny-sur-Orge near Paris, which allegedly sold 35 different models of total hip prostheses, of which only four had been endorsed by the Ministry of Health.

According to the investigators, a group of surgeons was paid Fr 6m (£750 000) in "royalties" to register about 900 unauthorised prostheses as being approved by the Ministry of Health. A number of prostheses

ruptured, and some patients had to be operated on several times.

Similar examples, concerning hip and knee prostheses, were revealed last year. More than 100 out of about 1200 orthopaedic surgeons in France face being sued for violating laws forbidding doctors to receive payments or gifts for prescribing orthopaedic equipment or drugs.—ALEXANDER DOROZYNSKI, medical journalist, Paris

North-south divide does not explain British poverty

The existence of an economic divide between the north and south of Britain is challenged in a new report by the Child Poverty Action Group. Instead, says the report, rich and poor people often live side by side. *Off the Map: the Social Geography of Policy in the UK* criticises the standard of health and other services offered to poor people and warns that the gap between the groups is widening.

Chris Philo, the editor of the report, said, "The north-south divide, although never eliminated, only tells half the story. There is a complex mosaic of living patterns and opportunities in the United Kingdom, leaving the have nots denied normal lifestyles, activities, and possessions generally expected by the majority."

Although the report disputes that the north-south divide gives a full picture of Britain's situation, it says that a major gulf still exists. In 1993 the average weekly income of a northern household was £291, while in the southeast it stood at £424. The study also claims that there is a Celtic divide, which leaves Irish, Welsh, and Scottish households trailing behind.

The gap between north and south has narrowed during the recession. While in the early 1980s the north lost 896 000 jobs to the south's 368 000, in the early 1990s the situation was reversed, with the north losing 503 000 to the south's 897 000.

The authors of the report argue that health and social policies must more closely reflect variations among local populations. The national survey of morbidity in general practice has shown that, in 1991, 12% of professional men and women reported serious illnesses but that the figure among unskilled manual workers was 21% for men and 20% for women.

There is also evidence that clinical outcomes are worse for poor people. The cancer registry statistics for southeast England show that people with prostate, lung, or breast cancer from underprivileged areas have lower survival rates at five years than those from wealthy districts, even though they may be treated by the same health authority.

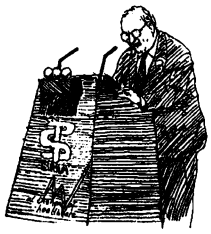
The report looks at the implications for health policy of the geographic differences in poverty. The Department of Health has given extra funds to regional health authorities in deprived areas. Until 1989 the calculations took account of local mortality statistics. For this reason the southeast, with its lower average mortality, had the slowest growing regional budget during this period. Southern regional health authorities argued that poor people in London's inner city were effectively penalised for living in a richer part of the country. In 1989 the formula was changed to take less account of mortality. But the report argues that redistribution of limted resources could achieve only so much.

A similar attempt has been made to increase equality in the provision of family health services by making deprivation payments to certain general practices.The report citicises tha current system as arbitrary in that wards falling below the threshold get nothing extra while poor people in affluent areas will not be treated as deprived.—OWEN DYER, freelance journalist, London

Off the Map: the Social Geography of Poverty in the UK is available from the Child Poverty Action Group, 1-5 Bath Street, London EC1V 9PY, price £8.95.

Focus: Harrogate

BMA needs a richer way to encourage participation



Much of the buzz at the BMA's annual representative meeting comes from the press. The press desks under the main platform are usually a hive of activity. Journalists scribble furiously, adjust their tape recorders, and troop in and out to hear medicopoliticians speak. And usually there is a row of television cameras, but this year there are none.

This year the ARM has had to compete for media attention with the twin attractions of a minor British film star arrested in Los Angeles for lewd behaviour and a tense election in the Conservative party for a new prime minister. Unfortunately, on the first day at least the ARM lost, and by the end of the afternoon the press benches were almost empty. But it wasn't only the missing press — and a large hall which felt empty — that gave the meeting a flat feel.

True, the chairman of council, Sandy Macara, delivered his opening speech (see p130) with his usual force and clarity and received a standing ovation. He celebrated the BMA's defeat of local pay bargaining, but Dr Macara's main emphasis was on the continuing message on the need to reform the reforms. The final point in his seven point plan for this re-reformation is the encouragement of cooperation, not competition, and there's some pleasure that the Labour party at least has picked up that theme in its own document on health policy (see also pp 75, 79, and 1 July, p13).

But the chairman's speech apart, many of the debates, covered familiar ground and reached conclusions that haven't changed much from last year — or, indeed, the year before. Counted votes suggested that at any one time barely half the representatives were present in the conference. Both contributed to the feeling, widely commented on by many representatives, that the debates were flat and uninspiring.

The meeting may well liven up: the GPs will debate their frustrations over out of hours arrangements, the scientific debates are always interesting, and there are new issues. But the underlying problem remains: the issues have probably outgrown the format's ability to handle them. Six hundred motions are listed for debate over four days, with most speakers confined to two minute slots. The subjects range from housekeeping measures within the BMA to the key medicopolitical issues facing doctors. Many of the motions are never debated, and any that are seem to be let down by ill prepared or absent speakers; many of the arguments are never heard because speakers don't get called or because the debate is curtailed. None of these criticisms is new. What is striking this year at Harrogate is the many representatives who openly commented on the event's lack of steam. Many similar professional organisations both in Britain and abroad have changed the format of their annual conferences. The Australian Medical Association and the Royal College of Nursing, for example, have meetings that allow for extended discussions on important issues. They build on policy work that has gone on during the year and use it to have well informed debates. Indeed, the BMA's own academic and consultants' conferences have moved in this direction.

The BMA has always been fiercely proud of its democracy, offering through divisions (and now through local negotiating committees), regional committees, the craft committees and conferences, and the ARM itself multiple opportunities for doctors to participate. Rightly, none of the elected officers wants to lose that ability to participate. But it may be that rethinking the ARM would allow richer ways of tapping that willingness to participate—and not leave so many empty seats.— JANE SMITH, *BMJ*